FOR OHF USE

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0005462

Facility Name: The Arthur Home

Address: 423 Eberhardt Drive (Number) Arthur (City) 61911 (Zip Code)

County: Moultrie

Telephone Number: (217)-543-2103 **Fax #** (217)-543-2278

IDPA ID Number: 370794402-0001

Date of Initial License for Current Owners: 1958

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501 (c)(3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Gary Coultrer, Administrator **Telephone Number:** (217)-543-2103

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 9/1/2001 to 8/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Gary Coulter
(Title) Administrator

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Kevin J. Huffman, CPA
(Firm Name & Address) McGuire, Yuhas, Huffman and Buckley, P.C. 334 West Eldorado Street Decatur, IL 62522-2192
(Telephone) (217)-543-2184 Fax # (217)-543-2185

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 9/1/2001 Ending: 8/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	69	Skilled (SNF)	69	25,185	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	69	TOTALS	69	25,185	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,436	90	366	1,892	8
9	SNF/PED					9
10	ICF	11,415	11,259	0	22,674	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,851	11,349	366	24,566	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.54%

D. How many bed-hold days during this year were paid by Public Aid?
101 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1958

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 7 and days of care provided 366

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 8/31/2002 Fiscal Year: 8/31/2002

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 9/1/2001 Ending: 8/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	184,974	10,611	3,414	198,999		198,999		198,999			1
2	Food Purchase		117,257		117,257		117,257	(3,619)	113,638			2
3	Housekeeping	78,577	8,992		87,569		87,569		87,569			3
4	Laundry	61,778	13,181		74,959	(8,207)	66,752		66,752			4
5	Heat and Other Utilities			52,846	52,846		52,846		52,846			5
6	Maintenance	37,479	7,651	28,117	73,247		73,247	(2,244)	71,003			6
7	Other (specify):*											7
8	**TOTAL General Services**	362,808	157,692	84,377	604,877	(8,207)	596,670	(5,863)	590,807			8
	B. Health Care and Programs											
9	Medical Director			4,000	4,000		4,000		4,000			9
10	Nursing and Medical Records	942,275	63,897	27,286	1,033,458	27,858	1,061,316		1,061,316			10
10a	Therapy			844	844		844		844			10a
11	Activities	93,974	5,654	2,934	102,562	(30,162)	72,400		72,400			11
12	Social Services					30,162	30,162		30,162			12
13	Nurse Aide Training			100	100		100		100			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,036,249	69,551	35,164	1,140,964	27,858	1,168,822		1,168,822			16
	C. General Administration											
17	Administrative	141,635			141,635	(78,953)	62,682		62,682			17
18	Directors Fees											18
19	Professional Services			41,223	41,223		41,223		41,223			19
20	Dues, Fees, Subscriptions & Promotions			9,954	9,954	274	10,228	(883)	9,345			20
21	Clerical & General Office Expenses		13,063	9,922	22,985	59,302	82,287	(3,360)	78,927			21
22	Employee Benefits & Payroll Taxes			265,156	265,156		265,156		265,156			22
23	Inservice Training & Education											23
24	Travel and Seminar			8,093	8,093		8,093		8,093			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			44,655	44,655		44,655		44,655			26
27	Other (specify):*			5,015	5,015	(274)	4,741	(3,440)	1,301			27
28	**TOTAL General Administration**	141,635	13,063	384,018	538,716	(19,651)	519,065	(7,683)	511,382			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,540,692	240,306	503,559	2,284,557		2,284,557	(13,546)	2,271,011			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number The Arthur Home #0005462 Report Period Beginning: 9/1/2001 Ending: 8/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			66,804	66,804		66,804		66,804			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			66,804	66,804		66,804		66,804			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			37,777	37,777		37,777		37,777			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			37,777	37,777		37,777		37,777			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,540,692	240,306	608,140	2,389,138		2,389,138	(13,546)	2,375,592			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 9/1/2001 Ending: 8/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,619)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,360)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(147)	27		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(250)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(848)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (8,224)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (8,224)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

The Arthur Home

ID# 0005462

Report Period Beginning: 9/1/2001

Ending: 8/31/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non-Program Expense	$ (3,043)	27	1
2	Public Relations-Association of Commerce Dues	(35)	20	2
3	Transportaton Fees	(2,244)	6	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(5,322)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 9/1/2001 Ending: 8/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,619)	0	0	0	0	0	0	0	0	0	0	(3,619)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(2,244)	0	0	0	0	0	0	0	0	0	0	(2,244)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(5,863)	0	0	0	0	0	0	0	0	0	0	(5,863)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(883)	0	0	0	0	0	0	0	0	0	0	(883)	20
21	Clerical & General Office Expenses	(3,360)	0	0	0	0	0	0	0	0	0	0	(3,360)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(3,440)	0	0	0	0	0	0	0	0	0	0	(3,440)	27
28	**TOTAL General Administration**	(7,683)	0	0	0	0	0	0	0	0	0	0	(7,683)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(13,546)	0	0	0	0	0	0	0	0	0	0	(13,546)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Arthur Home # 0005462 **Report Period Beginning:** 9/1/2001 **Ending:** 8/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(13,546)	0	0	0	0	0	0	0	0	0	0	(13,546)	45

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 9/1/2001 Ending: 8/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A Not for Profit Corporation-See attached schedule for members of the board of directors.						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 9/1/2001 Ending: 8/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2	None										2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 9/1/2001 Ending: 8/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 9/1/2001 Ending: 8/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3	No interest expense incurred											3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 9/1/2001 Ending: 8/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1997	None	8
1998	None	9
1999	None	10
2000	None	11
2001	None	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The Arthur Home COUNTY Moultrie

FACILITY IDPH LICENSE NUMBER 0005462

CONTACT PERSON REGARDING THIS REPORT Gary Coulter

TELEPHONE 217-543-2103 FAX #: 217-543-2278

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	None	Exempt Organization	$ None	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES N/A NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 9/1/2001 Ending: 8/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 22,236 B. General Construction Type: Exterior Brick Veneer Frame Concrete,Wood,Steel Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Rental Property - See page 13, schedule F. This is an adjacent single family rental house. Not related to nursing care.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	152,469	1959	$ 2,085	1
2					2
3	TOTALS	152,469		$ 2,085	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 9/1/2001 Ending: 8/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	40		1959	1959	$ 124,966	$	33	$	$	$ 124,966	4
5	29		1975	1975	308,251	9,341	33	9,341		256,596	5
6											6
7											7
8											8
	Improvement Type**										
9	New Roof			1972	1,988		10			1,988	9
10	Fire Door/Sprinkler			1973	25,066		10			25,066	10
11	Building Improvement			1974	8,635		10			8,635	11
12	Remodeling			1976	4,899		10			4,899	12
13	Insulation			1977	3,094		10			3,094	13
14	Building Improvement			1978	4,020		10			4,020	14
15	Seamless Floors			1979	9,036		10			9,036	15
16	Building Improvement			1979	4,228		10			4,228	16
17	Remodel Kitchen			1980	12,772		10			12,772	17
18	Roof and Building Improvements			1981	24,368		10			24,368	18
19	Building Improvement			1982	5,346		10			5,346	19
20	Heating System			1982	22,500		10			22,500	20
21	Building Improvement			1983	8,453		10			8,453	21
22	Overhang			1983	2,210		10			2,210	22
23	New Roof			1984	11,137		10			11,137	23
24	Remodel Paint Room			1985	1,214		10			1,214	24
25	New Front Door			1985	2,333		10			2,333	25
26	New Bath/Beauty Shop			1986	13,969		10			13,969	26
27	Remodel Med Room			1986	1,886		10			1,886	27
28	Sprinkler System			1987	1,971	79	25	79		1,211	28
29	Fire Doors			1987	1,097		10			1,097	29
30	Garage			1987	6,834	342	20	342		5,158	30
31	Boiler/Furnace Additions			1987	97,926	3,917	25	3,917		59,734	31
32	Floor Replacement			1987	1,016	51	20	51		756	32
33	Water Heater			1987	3,238	216	15	216		3,204	33
34	Garage Wiring			1987	916	46	20	46		678	34
35	Floor Replacement			1988	900	45	20	45		630	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 9/1/2001 Ending: 8/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Doorways	1989	$ 401	$ 20	20	$ 20	$	$ 272	37
38	Sprinkler System	1989	2,523	101	25	101		1,372	38
39	Patio	1989	2,384	119	20	119		1,587	39
40	Replacement Window	1988	2,100	105	20	105		1,452	40
41	Kitchen Fire Door	1989	1,005	40	25	40		513	41
42	New Flooring	1990	35,477	1,774	20	1,774		22,322	42
43	Shower Room/Basement Remodel	1990	8,024	401	20	401		4,988	43
44	Patient Alarm	1990	3,172		10			3,172	44
45	Curtain Tracks	1991	679		10			679	45
46	Door	1992	2,056	103	10	103		2,060	46
47	Ramp	1992	6,007	240	25	240		2,520	47
48	Gazebo	1992	10,636	532	20	532		5,542	48
49	Sprinkler System	1992	22,385	895	25	895		9,254	49
50	Building Improvement	1992	1,560	78	20	78		793	50
51	Remodel D/O/N Office	1993	3,970	199	20	199		1,857	51
52	Air Conditioners	1993	4,679	468	10	468		4,251	52
53	Building Improvement	1993	6,195	310	20	310		3,020	53
54	Ramp, rails, heater	1994	8,030	401	20	401		3,510	54
55	Roof Work	1994	3,150	158	20	158		1,341	55
56	Building Improvement	1994	1,484	74	20	74		637	56
57	Windows	1995	39,488	1,974	20	1,974		12,247	57
58	Nurse Call System	1995	10,082	1,008	10	1,008		7,560	58
59	Water Heater and Bed Lights	1995	4,664	466	10	466		3,661	59
60	Flooring and Doors	1995	3,187	159	20	159		1,149	60
61	Hot Water Pipes	1996	2,576	129	20	129		838	61
62	Shower Room Remodeling	1996	1,707	85	20	85		524	62
63	Lights	1996	1,366	68	20	68		403	63
64	Air Conditioners	1996	4,730	473	10	473		2,799	64
65	Lavatory	1997	1,778	89	20	89		519	65
66	Flooring	1997	15,671	784	20	784		4,377	66
67	Recovering Walls	1997	27,143	2,714	10	2,714		14,249	67
68	Building Improvement	1997	2,679	134	20	134		737	68
69	Air Conditioners	1998	6,751	675	10	675		3,263	69
70	TOTAL (lines 4 thru 69)		$ 1,025,465	$ 30,765		$ 30,765	$	$ 750,906	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 9/1/2001 Ending: 8/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Miscellaneous Improvements	1998	$ 2,802	$ 140	20	$ 140	$	$ 630	37
38	Basement Steel	1998	4,639	232	20	232		1,025	38
39	Architectural Fees	1998	10,950	548	20	548		2,420	39
40	Insulation	1998	3,600	180	20	180		720	40
41	Parking Spaces	1999	1,596	64	25	64		235	41
42	Exhaust Fan	1999	221	11	20	11		39	42
43	Install Steel Plates over Gutters	2000	484	24	20	24		70	43
44	Sink and Faucet	2000	1,401	93	15	93		248	44
45	Ducts	2000	404	20	20	20		52	45
46	Basement Doors	2001	1,058	53	20	53		88	46
47	Back Doors	2001	2,687	134	20	134		168	47
48	Alarm System	2001	2,075	208	10	208		312	48
49	Ceiling Improvements	2001	500	25	20	25		27	49
50	Grease Trap	2001	2,531	127	20	127		127	50
51	New Roof	2002	27,020	56	20	56		56	51
52	Miscellaneous Improvements	2002	1,489	37	20	37		37	52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69	Totals Below are this page only								69
70	TOTAL (lines 4 thru 69)		$ 63,457	$ 1,952		$ 1,952	$	$ 6,254	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 9/1/2001 Ending: 8/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 250,352	$ 24,068	$ 24,068	$	15,10,5	$ 134,993	71
72	Current Year Purchases	15,924	695	695		10	695	72
73	Fully Depreciated Assets	324,628					324,628	73
74								74
75	TOTALS	$ 590,904	$ 24,763	$ 24,763	$		$ 460,316	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Transportation	1982 Ford Econovan	1986	$ 7,000	$	$	$	4	$ 7,000	76
77	Resident Transportation	1991 Ford Aerostar Van	1991	15,110				4	15,110	77
78	Resident Transportation	2001 Ford Supreme Bus	2001	45,103	11,276	11,276		4	14,157	78
79										79
80	TOTALS			$ 67,213	$ 11,276	$ 11,276	$		$ 36,267	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,685,667	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 66,804	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 66,804	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,247,489	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Donated Farm Land	$ 22,500	$	$	86
87	Rental House 415 S.Oak St.Arthur	86,862	2,735	17,169	87
88	8.8 Acres Farm Land-Lutheran Ch.	81,771			88
89					89
90					90
91	TOTALS	$ 191,133	$ 2,735	$ 17,169	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ ____ Description: ____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 9/1/2001 Ending: 8/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		100		100
9	TOTALS	$	$ 100	$	$ 100
10	SUM OF line 9, col. 1 and 2 (e)	$ 100			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 9/1/2001 Ending: 8/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 8/31/2002 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 695,204	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	208,797		3
4	Supply Inventory (priced at Cost)	14,528		4
5	Short-Term Investments	2,187		5
6	Prepaid Insurance	21,071		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 941,787	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	124,356		13
14	Buildings, at Historical Cost	1,094,328		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	658,117		16
17	Accumulated Depreciation (book methods)	(1,266,574)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 610,227	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,552,014	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 67,520	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	46,050		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 113,570	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 113,570	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,438,444	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,552,014	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 9/1/2001 Ending: 8/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,217,154	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,217,154	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	221,290	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 221,290	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,438,444	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 9/1/2001 Ending: 8/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,619,375	1
2	Discounts and Allowances for all Levels	(206,021)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,413,354	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	3,619	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 3,619	23
	D. Non-Operating Revenue		
24	Contributions	169,523	24
25	Interest and Other Investment Income***	20,264	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 189,787	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Net Rental $467; Vending $15; Activity Dept $643	1,125	28
28a	Transportation Svcs $2244; Miscellaneous $299	2,543	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,668	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,610,428	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	604,877	31
32	Health Care	1,140,964	32
33	General Administration	538,716	33
	B. Capital Expense		
34	Ownership	66,804	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	37,777	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,389,138	40
41	**Income before Income Taxes (line 30 minus line 40)****	221,290	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 221,290	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 9/1/2001 Ending: 8/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,952	2,160	$ 44,397	$ 20.55	1
2	Assistant Director of Nursing	1,960	2,264	42,676	18.85	2
3	Registered Nurses	6,791	7,237	130,579	18.04	3
4	Licensed Practical Nurses	12,852	14,112	206,561	14.64	4
5	Nurse Aides & Orderlies	44,732	48,188	463,464	9.62	5
6	Nurse Aide Trainees	358	402	3,175	7.90	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,390	1,558	17,897	11.49	8
9	Activity Director	2,030	2,255	26,520	11.76	9
10	Activity Assistants	3,257	3,405	26,599	7.81	10
11	Social Service Workers	2,797	2,975	29,127	9.79	11
12	Dietician					12
13	Food Service Supervisor	2,054	2,286	33,399	14.61	13
14	Head Cook	2,000	2,227	20,704	9.30	14
15	Cook Helpers/Assistants	15,342	16,736	130,484	7.80	15
16	Dishwashers					16
17	Maintenance Workers	3,323	3,659	38,245	10.45	17
18	Housekeepers	7,261	8,182	78,512	9.60	18
19	Laundry	6,822	7,613	61,370	8.06	19
20	Administrator	2,016	2,160	61,712	28.57	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,475	1,893	27,663	14.61	23
24	Clerical	3,482	3,822	44,063	11.53	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,968	2,154	20,057	9.31	31
32	Other Health Care(specify)					32
33	Other(specify) Unit Aide	4,111	4,562	33,488	7.34	33
34	TOTAL (lines 1 - 33)	127,973	139,850	$ 1,540,692 *	$ 11.02	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	73	4,000	L9,C3	36
37	Medical Records Consultant	24	2,220	L10,C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	424	21,161	L10,C3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	96	2,934	L11, C3	44
45	Social Service Consultant				45
46	Other(specify) Dental	12	1,200	L10,C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	629	$ 31,515		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0		50
51	Licensed Practical Nurses		0		51
52	Nurse Aides		0		52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 9/1/2001 Ending: 8/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
Gary Coulter	Administrator	0	62,682
Shirley Stone	Office Manager	0	27,423
Linda Butler	Data Processing	0	31,879
Melissa Hodge	Medical Records	0	19,651
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 141,635

B. Administrative - Other

Description	Amount
None - See line 27	$ 0
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
American Express Tax&Business	Medicare Cert Consultant	$ 20,763
Daniel Maher	Attorney	1,300
McGuire,Yuhas,Huffman&Buckley	CPA's	6,550
Siedlund Associates	Assisted Living Study	2,500
Blair Minton & Associates	Assisted Living Study	9,165
Duane Morris	Attorney	945
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 41,223

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 36,126
Unemployment Compensation Insurance	7,275
FICA Taxes	119,446
Employee Health Insurance	100,348
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	311
Employee Assistance Program	1,650
TOTAL (agree to Schedule V, line 22, col.8)	$ 265,156

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	3,910
Health Care Worker Background Check	
(Indicate # of checks performed 47)	274
Subscriptions	155
Advertising	848
IL Health Care Association-Dues	4,253
Life Services Network-Dues	250
Other Health Care Org. Dues	503
Arthur Association of Commerce-Dues	35
Less: Public Relations Expense	(35)
Non-allowable advertising	(848)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,345

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Mileage @ .345/Mile	3,444
Parking	57
Hotel-$180; Meals-$306	486
Seminar Expense	4,106
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,093

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 9/1/2001 Ending: 8/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	None		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arthur Home **#** 0005462 **Report Period Beginning:** 9/1/2001 **Ending:** 8/31/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Health Care Association; $4,253**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **8,208** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **37,777**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **None** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **3,619**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **None**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **McGuire, Yuhas, Huffman & Buckley, P.C.** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

The Arthur Home
ID #0005462
FYE 9/1/2001-8/31/2002

Reclassifications:

Secretaries Salaries to Clerical (C21) from Administrative (C17)	$59,302
Medical Records Salaries (B10) to Nursing from Admin. (C17)	$19,651
Diaper Expense from Laundry (A4) to Nursing Supplies (B10)	$8,207
Social Services Salaries from Activity (B11) to Social Services (B12)	$30,162
IL State Police Background Checks from Admin. Other (C27) to Dues Fees, Subs (C20)	$274

Page 3, Line 27, Other, Consists of Unemployment Service (Personnel Planner) $720 and Miscellaneous Other $581

Page 15, Schedule XIII, A1: No nurse aide training programs were held because all aides were already certified. $100 was for a competency test done for a CNA who hadn't worked for several years and had to retake the test.

List of Board of Directors:

Gale Pearce	506 S. Pine	Arthur, IL 61911
Henry D. Herschberger	RR 2 Box 35	Arthur, IL 61911
Jody McGrath	510 S. Vine	Arthur, IL 61911
David Conlin	323 Orchard Lane	Arthur, IL 61911
Rick Weger	106 E. Columbia	Arthur, IL 61911
Paul Schrock	PO Box 409	Arthur, IL 61911
Alva Miller	350 N CR 475 E	Arthur, IL 61911

The Arthur Home
ID #0005462
FYE 9/1/2001-8/31/2002

Schedule V - Line 24 - Travel and Seminar:

In-State Mileage Reimb. @ .345	$3,444
Parking	$57
Meals	$307
Hotel	$180
Seminar Costs (See below)	$4,106
Total Travel and Seminar	$8,093

Date	Vendor/Sponsor	Check #	Costs	Date of Seminar	Individuals Attending	Job Title	Location	Title of Seminar
9/21/2001	ADA	9913	$155	10/20/2001	Janna Warner	Dietary Mgr	St. Louis	Food & Nutrition Conf.
9/25/2001	Lakeland College	9922	$90	10/4/2001	Gary Coulter	Administrator	Mattoon	Act & SS in Nursing Homes
10/6/2001	IL Health Care Association	9949	$430	10/25/2001	Gary Coulter	Administrator	Springfield	Clinical Issues-Infection Ctrl
					Melissa Dycus	DON		
					Marilyn Owens	ADON		
########	Resource Systems	9975	$396	10/30/2001	Gary Coulter	Administrator	Bloomington	Correcting the Leaks
					Melissa Dycus	DON		
					Marilyn Owens	ADON		
########	INHAA	9999	$65	11/7-8 '01	Gary Coulter	Administrator	East Peoria	Imp Message for NH Admin in IL
11/8/2001	Cooperative Extension Service	10035	$25	11/7/2001	Glenda Claypool	Head Cook	Decatur	Food Handlers Workshop
11/8/2001	IL Health Care Association	10057	$85	11/13/2001	Gary Coulter	Administrator	Mt. Vernon	Risk Management
########	OCC	10168	$180	1/30/2002	Gary Coulter	Administrator	Springfield	Abuse & Neglect Detection & Prevention
1/1/2002	IDPA/IHCA	10255	$400	2/20/2002	Gary Coulter	Administrator	Springfield	IOC Provider Training
					Melissa Dycus	DON		
					Jennifer Kauffman	RN,CPC		
					JoEllen Schultz	Activity Director		
1/1/2002	Outcome Services of IL	10274	$130	2/12/2002	Colleen Higginson	Activity Asst.	Mt. Vernon	"They're Back"
2/21/2002	IL Health Care Association	10335	$70	3/6/2002	Vicky Forbes	ADON	Springfield	Making the IOC Work for your Facility
3/13/2002	IL Health Care Association	10370	$370	4/4/2002	Gary Coulter	Administrator	Springfield	Act. As Part of IOC Team
					Melissa Dycus	DON		
					Vicky Forbes	ADON		
					JoEllen Schultz	Activity Director		
					Colleen Higginson	Activity Asst.		
3/13/2002	INHAA	10371	$85	4/11-12/02	Gary Coulter	Administrator	Springfield	Race to Excellence
4/9/2002	IL Health Care Association	10457	$325	4/23-24/02	Melissa Dycus	DON	Bloomington	2002 Resources for Success Conference
					Vicky Forbes	ADON		
5/2/2002	Enloe Drugs, LLC/Smith&Nephew,Inc.	10546	$50	5/29/2002	Melissa Dycus	DON	Decatur	Options
					Vicky Forbes	ADON		
5/13/2002	IL Health Care Association	10562	$160	6/12/2002	Melissa Dycus	DON	Springfield	Medication Mgmt in Long Term Care
					Vicky Forbes	ADON		
5/13/2002	IL Health Care Association	10563	$230	6/25-26/02	Gary Coulter	Administrator	Mt. Vernon	MDS Advanced
					Jennifer Kauffman	RN,CPC	Springfield	
					Rhonda Mills	LPN	Springfield	
5/31/2002	INHAA	10586	$65	6/26-27/02	Gary Coulter	Administrator	East Peoria	INHAA Conference
6/17/2002	IL Health Care Association	10649	$250	7/10/2002	Gary Coulter	Administrator	Springfield	HIPAA Compliance
					Jennifer Kauffman	RN,CPC		
7/27/2001	IL Health Care Association	10766	$545	9/9-11/02	Gary Coulter	Administrator	Springfield	IHCA Convention
					Melissa Dycus	DON		
					Vicky Forbes	ADON		
					Jennifer Kauffman	RN,CPC		
					Rhonda Mills	LPN		
					Janna Warner	Dietary Mgr		
					JoEllen Schultz	Activity Director		
					Linda Butler	Data Processing		
					Colleen Higginson	Activity Asst.		
					Cindy May	Activity Aide		
					Glenda Claypool	Head Cook		
					Lisa Kidwell	Dietary Aide		
			$4,106					